DFRRBAE0130011700046

DTS - ICES MS61
100 N SENATE AVE
INDIANAPOLIS, IN 46204

Mailing Date : 11/20/2015
Case : 3001170004

0000001

BRUCE CAMPBELL
C9.2 PC0486
INDY, IN 46237

Phone : (800) 403-0864
Fax : (800) 403-0864

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

It's time for your annual Medicaid/Hoosier Healthwise/Healthy Indiana Plan (HIP) eligibility review. We need to review your information and complete a redetermination of eligibility in order for your health coverage to continue. We were unable to automatically determine if you are eligible for an additional 12 months of coverage using the information that we have. Please review the information on the form included.

If all of the information is correct:

You do not need to respond to this notice. We will send you another notice with information about your new benefit year.

If you need to change any of the information:

Please write the correct information on the form next to the item you are changing or correcting. Sign the enclosed Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form and return it to us by the due date shown on the form. If you have any questions, please call the FSSA Call Center at 1-800-403-0864 between 8:00 a.m. and 4:30 p.m. You may include proof of any changes along with the form. We may also request proof of any changes and will notify you in writing if we need such proof. Failing to provide requested documents or information could affect your eligibility for health coverage.

Return your completed form and any additional documents to:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

Or Fax to the FSSA Document Center at 1-800-403-0864

Or you may also take your completed form to the Division of Family Resources in your county. The locations of these offices are available at www.fssa.in.gov or by calling 1-800-403-0864.

This form asks information about resources (assets). Resource (asset) information is only needed for determining eligibility for Medicaid for the Aged, Blind, Disabled, and Medicare Savings Programs.

WHOSE ELIGIBILITY IS BEING REVIEWED?

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

The Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form lists the people shown in this case. Each person is shown as either "eligible" or "ineligible" which is the member's status in this case. We are currently reviewing the circumstances of the family in this case. It may be possible that someone shown as ineligible is receiving health coverage in another case. If that is true, please just write in the space provided: "receiving Medicaid/Hoosier Healthwise/HIP" as appropriate in the space available under "correction."

SPECIAL CIRCUMSTANCES FOR MEMBERS IN LONG TERM CARE

The Eligibility Review Form has questions about your income and assets. It explains for most situations whose information we need. However there are special rules for Medicaid members receiving long term care services. These rules apply to members who live in Medicaid facilities such as nursing homes, and those who are receiving Medicaid home and community-based waiver services.

You don't have to give income and asset information for:

1. Parents of children if the children 1) are under age 18 who are on Medicaid in the disability or blind categories, 2) live in Medicaid facilities such as nursing homes, or 3) those who are receiving Medicaid home- and community-based waiver services if the parents themselves are not on Medicaid.
2. Community spouses who are not on Medicaid unless they want to receive some of their spouse's income. A community spouse for this purpose is one whose spouse is in a Medicaid facility or receiving waiver services under the Aged and Disabled Waiver.

You must tell us about any annuities that the member and spouse have. This includes annuity purchases and any non-routine transactions taken on an existing annuity. With these actions that occur on and after November 1 2009, the State must be named the remainder beneficiary on the annuity. (Section 1917(c) of the Social Security Act)

Thank you.

DFRRBAE033001170O046

MEDICAID/HOOSIER HEALTHWISE/HIP ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise/HIP. This is information we show currently in your case. If there are changes, please write them in the space provided and provide documentation of the new information.

IF THERE ARE CHANGES PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATE THAN DECEMBER 07, 2015.

DON'T FORGET TO SIGN YOUR FORM ON THE LAST PAGE

HOME ADDRESS:

ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP	PHONE	OTHER PHONE
C9.2 PC0486		INDY, IN 46237		

CHANGES/CORRECTIONS

MAILING ADDRESS:

None

CHANGES/CORRECTIONS

We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the third column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid/Hoosier Healthwise/HIP member is no longer living at this address please give the current address if you know it.

NAME	BIRTH DATE	CURRENT STATUS	CORRECTIONS
BRUCE CAMPBELL	01-01-1950	ELIGIBLE	_____
BRYCE CAMPBELL	01-01-1960	ELIGIBLE	_____

List Additional household members and their relationship to eligible members:

EMPLOYMENT INFORMATION:

Attach pay stubs for the last 30 days or provide a statement from your employer for each employed member.

EMPLOYED MEMBER	EMPLOYER	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

DFRRBAE0430011700046

SELF EMPLOYMENT INFORMATION:

Attach a copy of your most current income tax return including all schedules. If you do not file taxes, we need a copy of your self-employment records of income and expenses for the past twelve (12) months.

SELF-EMPLOYED MEMBER	EMPLOYEE TYPE	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS

OTHER INCOME INFORMATION:

Attach proof of the amount of each income type received for the most recent full month. If you wish, you may include in your attachment more than one month of income for each type. Supplemental Security Income (SSI)is not counted. Child support, and veterans benefits are not counted for Hoosier Healthwise and HIP.

RECEIVED BY	TYPE OF INCOME	AMOUNT RECEIVED	FREQUENCY	CHANGES/CORRECTIONS

RESOURCE INFORMATION:

Attach proof of the amount of each resource received as of the first moment of the first day of the most recent month.

Resource (asset) information is only needed for determining eligibility for Medicaid for the Aged, Blind, Disabled, and Medicare Savings Programs.

OWNER	RESOURCE TYPE	CASH VALUE	ADDITIONAL INFORMATION	CHANGES/CORRECTIONS

MILLER TRUST ACCOUNT:

OWNER NAME	AMOUNT ADDED TO TRUST	FREQUENCY	CHANGES/CORRECTIONS

ADDITIONAL INFORMATION: IF YOU HAVE ADDITIONAL INFORMATION TO REPORT, PLEASE ENTER THAT INFORMATION BELOW AND ATTACH DOCUMENTATION OF THE CHANGE.

Do you want to register to vote? (This will not affect your health coverage benefits.) ___Yes ___No

YOUR SIGNATURE IS REQUIRED:

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

Signature Date signed (month, day, year)

Witness signature if above is signed with "X" _____

PLEASE MEET THE REQUESTED DEADLINE SO THAT WE CAN PROCESS YOUR ELIGIBILITY REVIEW WITHOUT DELAY.

You may receive a request from us if we need additional information or proof of any changes that you have indicated or that we discover. Please be advised that failing to provide requested information could affect your eligibility for health coverage. You will also receive a notice on whether your health coverage benefits will continue or end based on your eligibility redetermination.

THANK YOU VERY MUCH FOR YOUR COOPERATION.

DFRRBAE0130011700462

DTS - ICES MS61
100 N SENATE AVE
INDIANAPOLIS, IN 46204

Mailing Date : 11/20/2015
Case : 3001170046

0000002

CHANNING TATUM
C10.2 PC0486
INDY, IN 46237

Phone : (800) 403-0864
Fax : (800) 403-0864

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

It's time for your annual Medicaid/Hoosier Healthwise/Healthy Indiana Plan (HIP) eligibility review. We need to review your information and complete a redetermination of eligibility in order for your health coverage to continue. To continue your coverage for another year we need you to complete, sign and return this form. If you do not complete, sign and return this form and are a member of the Healthy Indiana Plan you will not be able to continue your Healthy Indiana Plan coverage and will not be able to reapply for coverage for a period of six months after the end of your current benefits. You may include proof of any changes along with the form. We may request further proof of any changes and will notify you in writing if we need such proof. Failing to provide requested documents or information could affect your eligibility for health coverage.

Sign the enclosed Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form and return it to us by the due date shown on the form. If you have any questions, please call the FSSA Call Center at 1-800-403-0864 between 8:00 a.m. and 4:30 p.m.

Return your completed form and any additional documents to:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

Or Fax to the FSSA Document Center at 1-800-403-0864

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WHOSE ELIGIBILITY IS BEING REVIEWED?

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true, please just write in the space provided: "receiving Medicaid/Hoosier Healthwise/HIP" as appropriate in the space available under "correction."

SPECIAL CIRCUMSTANCES FOR MEMBERS IN LONG TERM CARE

The Eligibility Review Form has questions about your income and assets. It explains for most situations whose information we need. However there are special rules for Medicaid members receiving long term care services. These rules apply to members who live in Medicaid facilities such as nursing homes, and those who are receiving Medicaid home and community-based waiver services.

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2. Community spouses who are not on Medicaid unless they want to receive some of their spouse's income. A community spouse for this purpose is one whose spouse is in a Medicaid facility or receiving waiver services under the Aged and Disabled Waiver.

You must tell us about any annuities that the member and spouse have. This includes annuity purchases and any non-routine transactions taken on an existing annuity. With these actions that occur on and after November 1 2009, the State must be named the remainder beneficiary on the annuity. (Section 1917(c) of the Social Security Act)

Thank you.

DFRRBAE0330011700462

MEDICAID/HOOSIER HEALTHWISE/HIP ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise/HIP. This is information we show currently in your case. If there are changes, please write them in the space provided and provide documentation of the new information.

PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATER THAN DECEMBER 07, 2015.

DON'T FORGET TO SIGN YOUR FORM ON THE LAST PAGE

HOME ADDRESS:

ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP	PHONE	OTHER PHONE
C10.2 PC0486		INDY, IN 46237		

CHANGES/CORRECTIONS

MAILING ADDRESS:

None

CHANGES/CORRECTIONS

We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the third column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid/Hoosier Healthwise/HIP member is no longer living at this address please give the current address if you know it.

NAME	BIRTH DATE	CURRENT STATUS	CORRECTIONS
CHANNING TATUM	01-01-1949	ELIGIBLE	_____
CAROLYN TATUM	01-01-1959	ELIGIBLE	_____

List Additional household members and their relationship to eligible members:

EMPLOYMENT INFORMATION:

Attach pay stubs for the last 30 days or provide a statement from your employer for each employed member.

EMPLOYED MEMBER	EMPLOYER	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS
CHANNING TATUM	WORKING	$1500.00	MONTHLY	_____

SELF EMPLOYMENT INFORMATION:

Attach a copy of your most current income tax return including all schedules. If you do not file taxes, we need a copy of your self-employment records of income and expenses for the past twelve (12) months.

SELF-EMPLOYED MEMBER	EMPLOYEE TYPE	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

DFRRBAE043001170O462

OTHER INCOME INFORMATION:

Attach proof of the amount of each income type received for the most recent full month. If you wish, you may include in your attachment more than one month of income for each type. Supplemental Security Income (SSI)is not counted. Child support, and veterans benefits are not counted for Hoosier Healthwise and HIP.

RECEIVED BY	TYPE OF INCOME	AMOUNT RECEIVED	FREQUENCY	CHANGES/CORRECTIONS

RESOURCE INFORMATION:

Attach proof of the amount of each resource received as of the first moment of the first day of the most recent month.

Resource (asset) information is only needed for determining eligibility for Medicaid for the Aged, Blind, Disabled, and Medicare Savings Programs.

OWNER	RESOURCE TYPE	CASH VALUE	ADDITIONAL INFORMATION	CHANGES/CORRECTIONS

MILLER TRUST ACCOUNT:

OWNER NAME	AMOUNT ADDED TO TRUST	FREQUENCY	CHANGES/CORRECTIONS

ADDITIONAL INFORMATION: IF YOU HAVE ADDITIONAL INFORMATION TO REPORT, PLEASE ENTER THAT INFORMATION BELOW AND ATTACH DOCUMENTATION OF THE CHANGE.

Do you want to register to vote? (This will not affect your health coverage benefits.) ___Yes ___No

YOUR SIGNATURE IS REQUIRED:

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

_____

Signature Date signed (month, day, year)

Witness signature if above is signed with "X" _____

PLEASE MEET THE REQUESTED DEADLINE SO THAT WE CAN PROCESS YOUR ELIGIBILITY REVIEW WITHOUT DELAY.

You may receive a request from us if we need additional information or proof of any changes that you have indicated or that we discover. You will also receive a notice on whether your health coverage benefits will continue or end based on your eligibility redetermination.

THANK YOU VERY MUCH FOR YOUR COOPERATION.

DFRRAAE0130011699807

DTS - ICES MS61
100 N SENATE AVE
INDIANAPOLIS, IN 46204

Mailing Date : 11/20/2015
Case : 3001169980

0000003

ELLIOT GOULD
C9.1 PC0486
INDY, IN 46237

Phone : (800) 403-0864
Fax : (800) 403-0864

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

It's time for your annual Medicaid/Hoosier Healthwise/Healthy Indiana Plan (HIP) eligibility review. We need to review your information and complete a redetermination of eligibility in order for your health coverage to continue. We were unable to automatically determine if you are eligible for an additional 12 months of coverage using the information that we have. Please review the information on the form included.

If all of the information is correct:

You do not need to respond to this notice. We will send you another notice with information about your new benefit year.

If you need to change any of the information:

Please write the correct information on the form next to the item you are changing or correcting. Sign the enclosed Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form and return it to us by the due date shown on the form. If you have any questions, please call the FSSA Call Center at 1-800-403-0864 between 8:00 a.m. and 4:30 p.m. You may include proof of any changes along with the form. We may also request proof of any changes and will notify you in writing if we need such proof. Failing to provide requested documents or information could affect your eligibility for health coverage.

Return your completed form and any additional documents to:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

Or Fax to the FSSA Document Center at 1-800-403-0864

Or you may also take your completed form to the Division of Family Resources in your county. The locations of these offices are available at www.fssa.in.gov or by calling 1-800-403-0864.

WHOSE ELIGIBILITY IS BEING REVIEWED?

The Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form lists the people shown in this case. Each person is shown as either "eligible" or "ineligible" which is the member's status

in this case. We are currently reviewing the circumstances of the family in this case. It may be possible that someone shown as "ineligible" is receiving health coverage in another case. If that is true, please just write in the space provided: "receiving Medicaid/Hoosier Healthwise/HIP" as appropriate in the space available under "correction."

If anyone's tax filing status has changed or expects to change from the previous year when Medicaid eligibility was determined, you are required to report this change. Such changes would include whether a person files taxes or doesn't file taxes, and it would also include whether a dependent is claimed by a different person than during the previous year.

Thank you.

DFRRAAE033001699807

MEDICAID/HOOSIER HEALTHWISE/HIP ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise/HIP. This is information we show currently in your case. If there are changes, please write them in the space provided and provide documentation of the new information.

IF THERE ARE CHANGES PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATE THAN DECEMBER 07, 2015.

DON'T FORGET TO SIGN YOUR FORM ON THE LAST PAGE

HOME ADDRESS:

ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP	PHONE	OTHER PHONE
C9.1 PC0486		INDY, IN 46237		

CHANGES/CORRECTIONS

MAILING ADDRESS:

None

CHANGES/CORRECTIONS

We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the third column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid/Hoosier Healthwise/HIP member is no longer living at this address please provide the current address for that member if you know it.

NAME	BIRTH DATE	CURRENT STATUS	CORRECTIONS
ELLIOT GOULD	01-01-1980	ELIGIBLE	_____
EMMA GOULD	01-01-1980	ELIGIBLE	_____

List Additional household members and their relationship to eligible members:

EMPLOYMENT INFORMATION:

Attach pay stubs for the last 30 days or provide a statement from your employer for each employed member.

EMPLOYED MEMBER	EMPLOYER	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS

SELF EMPLOYMENT INFORMATION:

Attach a copy of your most current income tax return including all schedules. If you do not file taxes, we need a copy of your self-employment records of income and expenses for the past twelve (12) months.

SELF-EMPLOYED MEMBER	EMPLOYEE TYPE	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS

DFRRAAE0430011699807

OTHER INCOME INFORMATION:

Attach proof of the amount of each income type received for the most recent full month. If you wish, you may include in your attachment more than one month of income for each type. Supplemental Security Income (SSI)is not counted. Child support, and veterans benefits are not counted for Hoosier Healthwise and HIP.

RECEIVED BY	TYPE OF INCOME	AMOUNT RECEIVED	FREQUENCY	CHANGES/CORRECTIONS

ADDITIONAL INFORMATION: IF YOU HAVE ADDITIONAL INFORMATION TO REPORT, PLEASE ENTER THAT INFORMATION BELOW AND ATTACH DOCUMENTATION OF THE CHANGE.

Do you want to register to vote? (This will not affect your health coverage benefits.) ___Yes ___No

YOUR SIGNATURE IS REQUIRED:

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

Signature Date signed (month, day, year)

Witness signature if above is signed with "X" _____

PLEASE MEET THE REQUESTED DEADLINE SO THAT WE CAN PROCESS YOUR ELIGIBILITY REVIEW WITHOUT DELAY.

You may receive a request from us if we need additional information or proof of any changes that you have indicated or that we discover. Please be advised that failing to provide requested information could affect your eligibility for health coverage. You will also receive a notice on whether your health coverage benefits will continue or end based on your eligibility redetermination.

THANK YOU VERY MUCH FOR YOUR COOPERATION.

DFRRAAE0130011700383

DTS - ICES MS61
100 N SENATE AVE
INDIANAPOLIS, IN 46204

Mailing Date : 11/20/2015
Case : 3001170038

0000004

MALINA BENNET
C10.1 PC0486
INDY, IN 46237

Phone : (800) 403-0864
Fax : (800) 403-0864

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

It's time for your annual Medicaid/Hoosier Healthwise/Healthy Indiana Plan (HIP) eligibility review. We need to review your information and complete a redetermination of eligibility in order for your health coverage to continue. To continue your coverage for another year we need you to complete, sign and return this form. If you do not complete, sign and return this form and are a member of the Healthy Indiana Plan you will not be able to continue your Healthy Indiana Plan coverage and will not be able to reapply for coverage for a period of six months after the end of your current benefits. You may include proof of any changes along with the form. We may request further proof of any changes and will notify you in writing if we need such proof. Failing to provide requested documents or information could affect your eligibility for health coverage.

Sign the enclosed Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form and return it to us by the due date shown on the form. If you have any questions, please call the FSSA Call Center at 1-800-403-0864 between 8:00 a.m. and 4:30 p.m.

Return your completed form and any additional documents to:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

Or Fax to the FSSA Document Center at 1-800-403-0864

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WHOSE ELIGIBILITY IS BEING REVIEWED?

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DFRRAAE0230011700383

If anyone's tax filing status has changed or expects to change from the previous year when Medicaid eligibility was determined, you are required to report this change. Such changes would include whether a person files taxes or doesn't file taxes, and it would also include whether a dependent is claimed by a different person than during the previous year.

Thank you.

DFRRAAE033001170O383

MEDICAID/HOOSIER HEALTHWISE/HIP ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise/HIP. This is information we show currently in your case. If there are changes, please write them in the space provided and provide documentation of the new information.

PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATER THAN DECEMBER 07, 2015.

DON'T FORGET TO SIGN YOUR FORM ON THE LAST PAGE

HOME ADDRESS:

ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP	PHONE	OTHER PHONE
C10.1 PC0486		INDY, IN 46237		

CHANGES/CORRECTIONS

MAILING ADDRESS:

None

CHANGES/CORRECTIONS

We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the third column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid/Hoosier Healthwise/HIP member is no longer living at this address please provide the current address for that member if you know it.

NAME	BIRTH DATE	CURRENT STATUS	CORRECTIONS
TOMMY BENNET	01-01-1980	ELIGIBLE	_____
MALINA BENNET	01-01-1980	ELIGIBLE	_____

List Additional household members and their relationship to eligible members:

EMPLOYMENT INFORMATION:

Attach pay stubs for the last 30 days or provide a statement from your employer for each employed member.

EMPLOYED MEMBER	EMPLOYER	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS
TOMMY BENNET	WORKING	$1500.00	MONTHLY	_____

SELF EMPLOYMENT INFORMATION:

Attach a copy of your most current income tax return including all schedules. If you do not file taxes, we need a copy of your self-employment records of income and expenses for the past twelve (12) months.

SELF-EMPLOYED MEMBER	EMPLOYEE TYPE	GROSS EARNINGS	FREQUENCY	CHANGES/CORRECTIONS

DFRRAAE0430011700383

OTHER INCOME INFORMATION:

Attach proof of the amount of each income type received for the most recent full month. If you wish, you may include in your attachment more than one month of income for each type. Supplemental Security Income (SSI)is not counted. Child support, and veterans benefits are not counted for Hoosier Healthwise and HIP.

RECEIVED BY	TYPE OF INCOME	AMOUNT RECEIVED	FREQUENCY	CHANGES/CORRECTIONS

ADDITIONAL INFORMATION: IF YOU HAVE ADDITIONAL INFORMATION TO REPORT, PLEASE ENTER THAT INFORMATION BELOW AND ATTACH DOCUMENTATION OF THE CHANGE.

Do you want to register to vote? (This will not affect your health coverage benefits.) ___Yes ___No

YOUR SIGNATURE IS REQUIRED:

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

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THANK YOU VERY MUCH FOR YOUR COOPERATION.

ICES
F3
MULTIPLES 2-4 Pages
TOTAL PAGES 16
FROM MAILER #1
TO MAILER #4
11/20/2015

FILE #1